

NY STATE CLIENT SEMI-ANNUAL REPORT

Marking Instructions: Please type or use blue or black ink pen.
 Completely fill in one circle.
 Print legible numbers and block letters, no script.

COMPLETE ALL SECTIONS
 before submitting or form will be returned.

I Reporting Information

Year: 2012

Fill in circle if amendment ☒

Report Period: ☐ January/June ☒ July/December

Type of Lobbying: ☒ Nonprocurement ☐ Procurement ☐ Both

Client Filing Fee Check Number:

FOR OFFICE USE ONLY

Cjm Amendment
 Amended: includes Sof F info

RECEIVED APR 11 2013

HAND DELIVERED

II Client Information

Name: New York Health Plan Association

Permanent Business Address: 90 State Street, Suite 825

City: Albany

State: NY

ZIP code: 1220

Business Phone: 518-462-2293

Fax Number: 518-462-2150

Third Party Beneficiary (see instructions): none

III Lobbyist(s) Information & Compensation (Current Period Only)

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

A Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

B Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

C Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

☐ Continued on attached pages

D TOTAL COMPENSATION of ALL lobbyists for current period.....(A+B+C+addendum sheets): \$.00

IV Other Expenses (Current Semi-Annual Period Only)

A Report in the aggregate all expenses less than or equal to \$75: \$.00

B Report in the aggregate all expenses for salaries of non-lobbying employees: \$.00

C Itemize each expense exceeding \$75:

PAID TO: DATE: / / ☐ Ad ☐ Social Event
PURPOSE: AMOUNT: \$.00 ☐ *Addendum attached
☐ PROCUREMENT ☐ NONPROCUREMENT

PAID TO: DATE: / / ☐ Ad ☐ Social Event
PURPOSE: AMOUNT: \$.00 ☐ *Addendum attached
☐ PROCUREMENT ☐ NONPROCUREMENT

☐ Continued on attached pages

* If any expense listed above exceeds \$75 for an individual, you must attach the addendum page listing the expense, dollar amount attributable to the individual and the name, title and employer of the individual.

D Total expenses for current period: \$.00 (if applicable, include all expenses from attached pages in total)

V Source of Funding Disclosure

Instructions: In the event only one person or entity is listed as the Single Source for a Contribution(s), use Section A. In the event multiple persons or entities have been aggregated as a Single Source for a Contribution(s), use Section B.
A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received. If more than five Contributions from the Single Source have been received, use section V(C) of the Addendum for the additional Contributions.

Contribution(s) from Single Source #1

Single Source Entity's Name: Aetna

or
Single Source Person's Last Name:

First Name:

Address: 100 Park Avenue, 12th Floor

City: NEW YORK

State: NY

ZIP code: 10017

Phone: 212-457-0457

Date Contribution Received: 03/12/12

Amount of Contribution: \$ 30,419.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contribution(s) Single Source #2

Single Source Entity's Name: AFFINITY HEALTH PLAN

or
Single Source Person's Last Name:

First Name:

Address: 2500 HALSEY ST

City: BRONX

State: NY

ZIP code: 10461

Phone: 718-794-7691

Date Contribution Received: 02/09/12

Amount of Contribution: \$ 7007.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(A) of the Addendum to list all such Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source #3

Single Source Entity's Name: AMERIGROUP

or

Single Source Person's Last Name:

First Name:

Address: 360 WEST 31ST ST, 5TH FLOOR

City: NEW YORK

State: NY

ZIP code: 10011

Phone: 212-372-6902

Date Contribution Received: 02/20/12

Amount of Contribution: \$ 8340.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 4

Single Source Entity's Name: CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN

or

Single Source Person's Last Name:

First Name:

Address: 500 PATROON CREEK BLVD

City: ALBANY

State: NY

ZIP code: 12206

Phone: 518-641-5550

Date Contribution Received: 03/23/12

Amount of Contribution: \$ 22,229.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 5

Single Source Entity's Name: ELDERPLAN

or

Single Source Person's Last Name:

First Name:

Address: 6323 7TH AVE

City: BROOKLYN

State: NY

ZIP code: 11220

Phone: 718-921-8066

Date Contribution Received: 02/06/12

Amount of Contribution: \$ 11,535.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source # 6Single Source Entity's Name: EMBLEM HEALTH SERVICESor
Single Source Person's Last Name:

First Name:

Address: 55 WATER STCity: NEW YORKState: NYZIP code: 10041Phone: 202-289-6507Date Contribution Received: 02/01/12Amount of Contribution: \$ 50,816.00Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source # 7**Single Source Entity's Name: FIDELIS CAREor
Single Source Person's Last Name:

First Name:

Address: 95-25 QUEENS BLVDCity: REGO PARKState: NYZIP code: 11374Phone: 718-896-1047Date Contribution Received: 02/01/12Amount of Contribution: \$ 12,539.00Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source # 8**Single Source Entity's Name: HEALTHFIRSTor
Single Source Person's Last Name:

First Name:

Address: 100 CHURCH ST 17TH FLOORCity: NEW YORKState: NYZIP code: 10007Phone: 212-801-1500Date Contribution Received: 02/09/12Amount of Contribution: \$ 10,475.00Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source # 9Single Source Entity's Name: HEALTH NOWor
Single Source Person's Last Name:

First Name:

Address: 257 WEST GENESEE STCity: BUFFALOState: NYZIP code: 14202Phone: 716-887-8691Date Contribution Received: 07/17/12Amount of Contribution: \$ 27,364.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source # 10**Single Source Entity's Name: HUDSON HEALTH PLANor
Single Source Person's Last Name:

First Name:

Address: 303 SO. BROADWAY SUITE 301City: TARRYTOWNState: NYZIP code: 10591Phone: 914-372-2211Date Contribution Received: 02/03/12Amount of Contribution: \$ 5,464.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Date Contribution Received: / /Amount of Contribution: \$.00Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source # 11**Single Source Entity's Name: INDEPENDENT HEALTHor
Single Source Person's Last Name:

First Name:

Address: 511 FARBER LAKES DRIVECity: BUFFALOState: NYZIP code: 14221Phone: 716-435-3714Date Contribution Received: 02/13/12Amount of Contribution: \$ 1786.00Date Contribution Received: 03/24/12Amount of Contribution: \$ 1786.00Date Contribution Received: 04/17/12Amount of Contribution: \$ 1786.00Date Contribution Received: 05/22/12Amount of Contribution: \$ 1786.00Date Contribution Received: 06/19/12Amount of Contribution: \$ 1786.00Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source # 12

Single Source Entity's Name: METRO PLUS

or

Single Source Person's Last Name:

First Name:

Address: 160 WATER ST 12TH FLOOR

City: NEW YORK

State: NY

ZIP code: 10038

Phone: 212-908-8590

Date Contribution Received: 02/06/12

Amount of Contribution: \$ 9,351.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 13

Single Source Entity's Name: MVP HEALTH CARE

or

Single Source Person's Last Name:

First Name:

Address: 625 STATE ST

City: SCHENECTADY

State: NY

ZIP code: 12305

Phone:

Date Contribution Received: 01/23/12

Amount of Contribution: \$ 25,029.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 14

Single Source Entity's Name: NEIGHBORHOOD HEALTH PROVIDERS

or

Single Source Person's Last Name:

First Name:

Address: 521 5TH AVE 3RD FLOOR

City: NEW YORK

State: NY

ZIP code: 10175

Phone: 212-808-4775

Date Contribution Received: 04/26/12

Amount of Contribution: \$ 8,361.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source # 15

Single Source Entity's Name: SENIOR HEALTH PARTNERS

or

Single Source Person's Last Name:

First Name:

Address: 345 EAST 102ND ST SUITE 200

City: NEW YORK

State: NY

ZIP code: 10029

Phone: 212-324-2612

Date Contribution Received: 02/09/12

Amount of Contribution: \$ 2,691.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 14

Single Source Entity's Name: SENIOR WHOLE HEALTH

or

Single Source Person's Last Name:

First Name:

Address: 58 CHARLES ST

City: BOSTON

State: MA

ZIP code: 02141

Phone: 578-472-5200

Date Contribution Received: 02/03/12

Amount of Contribution: \$ 2,691.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 17

Single Source Entity's Name: TOTAL CARE

or

Single Source Person's Last Name:

First Name:

Address: 819 SOUTH SALINA ST

City: SYRACUSE

State: NY

ZIP code: 13202

Phone: 315-476-7921

Date Contribution Received: 01/30/12

Amount of Contribution: \$ 4,534.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source # 18

Single Source Entity's Name: UNITED HEALTHCARE

or
Single Source Person's Last Name:

First Name:

Address: 90 STATE ST SUITE 700

City: ALBANY

State: NY

ZIP code: 12207

Phone: 518-591-4637

Date Contribution Received: 02/23/12

Amount of Contribution: \$ 37,007.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 19

Single Source Entity's Name: VNS CHOICE

or
Single Source Person's Last Name:

First Name:

Address: 1250 BROADWAY 11TH FLOOR

City: NEW YORK

State: NY

ZIP code: 10001

Phone: 212-609-5631

Date Contribution Received: 02/13/12

Amount of Contribution: \$ 2,691.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source # 20

Single Source Entity's Name: WELL CARE

or
Single Source Person's Last Name:

First Name:

Address: 110 5TH AVENUE 3RD FLOOR

City: NEW YORK

State: NY

ZIP code: 10011

Phone: 917-229-2018

Date Contribution Received: 01/30/12

Amount of Contribution: \$ 9,670.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

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Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

Instructions: Below, list all Contributions received from the Single Source or, if applicable, the Related, Affiliated Entity or Person. Include the date of the Contribution received and the amount of the Contribution.

Contributions from Single Source # 11

Single Source (or Related or Affiliated) Entity's Name: INDEPENDENT HEALTH

or
Single Source (or Related or Affiliated) Person's Last Name:

First Name:

Address: 571 FARBER LAKES DRIVE

City: BUFFALO

State: NY

ZIP code: 14221

Phone: 716-635-3714

Date Contribution Received: 03/20/12 Amount of Contribution: \$ 1786.00

Date Contribution Received: 10/24/12 Amount of Contribution: \$ 7142.00

Date Contribution Received: 12/13/12 Amount of Contribution: \$ 3571.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

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Date Contribution Received: / / Amount of Contribution: \$.00

VI Subjects lobbied:

☐ Continued on attached pages

VII Person, State Agency, Municipality or Legislative Body lobbied:

☐ Continued on attached pages

VII Bill, Rule, Regulation, Rate Number or brief description relative to the introduction or intended introduction of legislation or a resolution on which you lobbied:

☐ Continued on attached pages

VIII Title and Identifying Numbers of procurement contracts/documents lobbied:

☐ Continued on attached pages

IX Number or Subject Matter of Executive Order of Governor/Municipality lobbied:

☐ Continued on attached pages

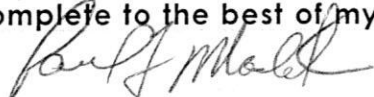
X Subject Matter of and Tribes involved in tribal-state compacts, etc lobbied:

☐ Continued on attached pages

XI Declaration

This Declaration must be signed by the Chief Administrative Officer. (If the Chief Administrative Officer, for any reason, does not sign, he/she must duly designate another person to sign this Declaration.) **(See instructions.)**

I declare under penalty of perjury that the information contained in this report is true, correct, and complete to the best of my knowledge and belief.

X SIGNATURE:

DATE: April 8, 2013

PRINT NAME: LAST Macielak

FIRST Paul

TITLE: President & CEO

Mark One: ☒ Chief Administrative Officer ☐ Designee(Attach Letter)**The following MUST be attached to this report at the time of submission:**

- You must attach a **\$50 dollar filing fee** to each semi-annual report. (No fee is required for amendments to the original)
- If applicable, a designation letter if you have marked designee in section XI.
- If applicable, continuation sheets for sections III, IV, V, VI, VII, VIII, IX and X.

PLEASE NOTE You may be assessed up to \$25 for each day this report is late.